

# **Attacking the Health Care Monster: Hard Decisions Ahead For Our Society**

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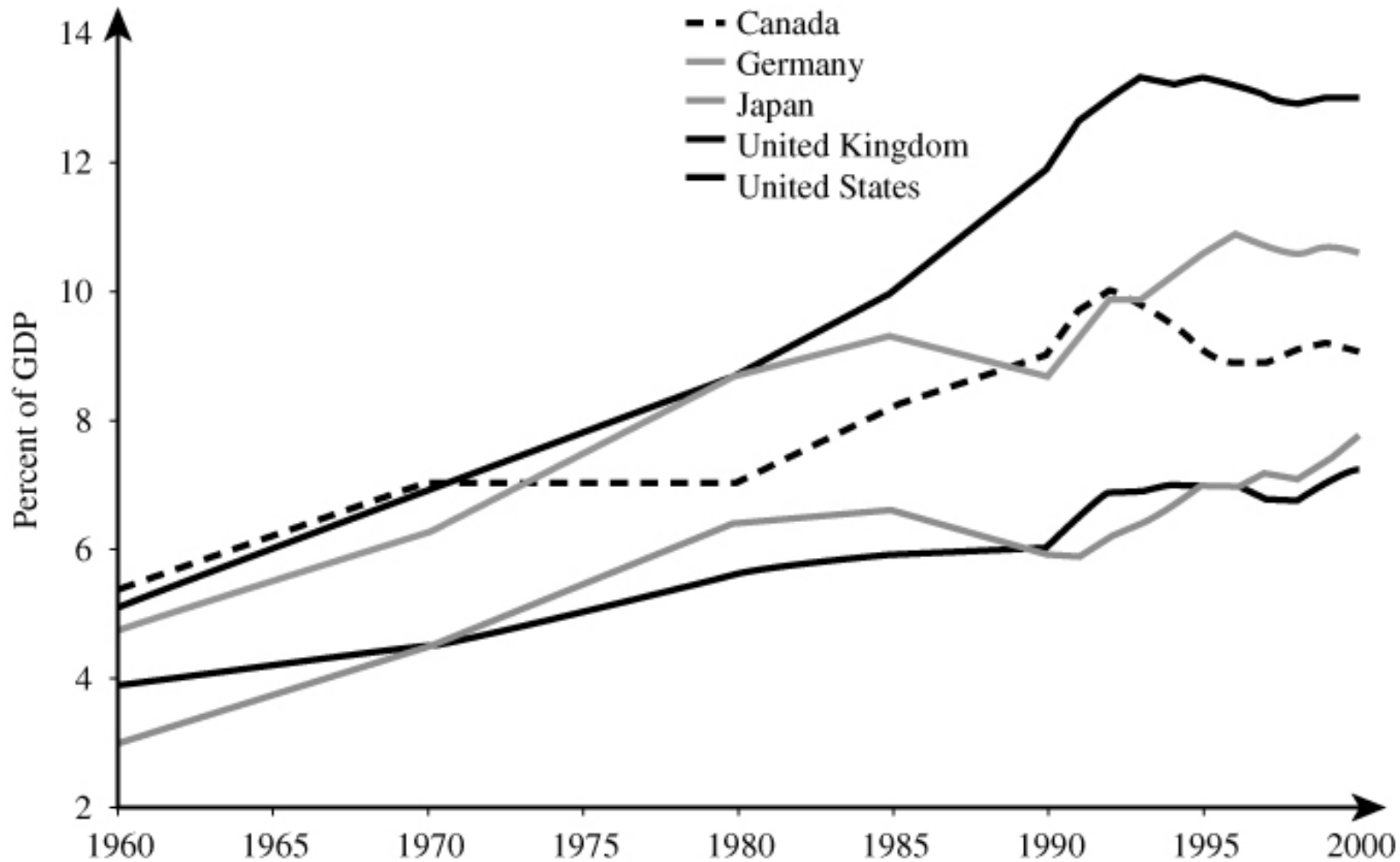
**Presentation for *Lexington  
Employee Benefits Council,*  
Sheraton Suites, Lexington, KY**

# Overview of talk

- Twin problems – Access and Cost
- Market failures in health care
- Policy proposals

# Twin Problems: Access and Cost

- The health care system in the United States is much different than most other developed countries.
- Private market plays a much larger role in the provision of health care in the U.S.
- Health care costs and the number of uninsured higher in U.S.
- Quality / technology is better in U.S., too.



**Table 10.2 National health expenditures (selected years)**

<i>Year</i>	<i>Total Expenditures (in billions of dollars)</i>	<i>Percent of GDP</i>	<i>Public Share as Percent of Total Health Expenditure<sup>†</sup></i>
1970	\$ 73	7.0%	37.8%
1980	246	8.8	42.7
1990	696	12.0	40.6
1997	1,091	13.1	46.0
2000	1,300	13.2	45.2
2011*	2,800*	17.0*	—

\*Projections.

<sup>†</sup>Includes federal, state, and local.

SOURCE: "Health United States 2002," Centers for Disease Control and Prevention [URL: [www.cdc.gov](http://www.cdc.gov)]. Projections for 2011 from Centers for Medicare and Medicaid Services [URL: [www.cms.hhs.gov](http://www.cms.hhs.gov)].

**Table 10.3 Real health expenditures per capita in selected countries\***

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Canada	\$2,535
Germany	2,748
Japan	2,012
United Kingdom	1,763
United States	4,631

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\*2000 US dollars.

SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2002*, Table 9, [URL: [www.oecd.org](http://www.oecd.org)].

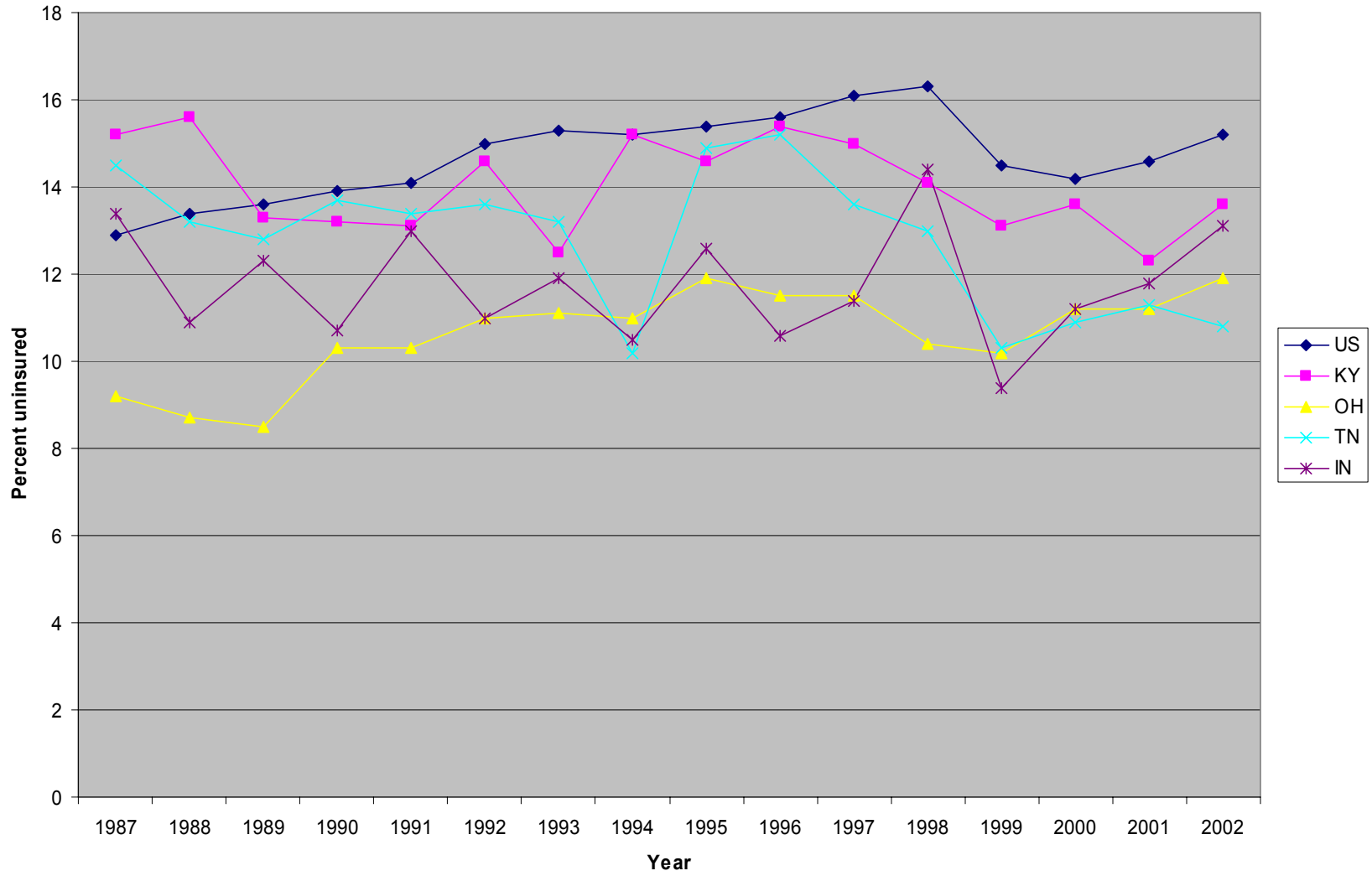
## Access: Some Facts About Uninsured

- For the U.S. as a whole, 15.2% uninsured for entire calendar year in 2002. This amounts to 43.6 million people.
- For Kentucky, 13.6% uninsured, 548 thousand people.
- Lexington MSA uninsured slightly higher than the state as a whole.

## Access: Some Facts About Uninsured

- Kentucky and several neighboring states (Ohio, Indiana, Tennessee) consistently have higher insurance rates than the U.S. as a whole.
- Compared with these states, however, Kentucky tends to lag in insurance rates.

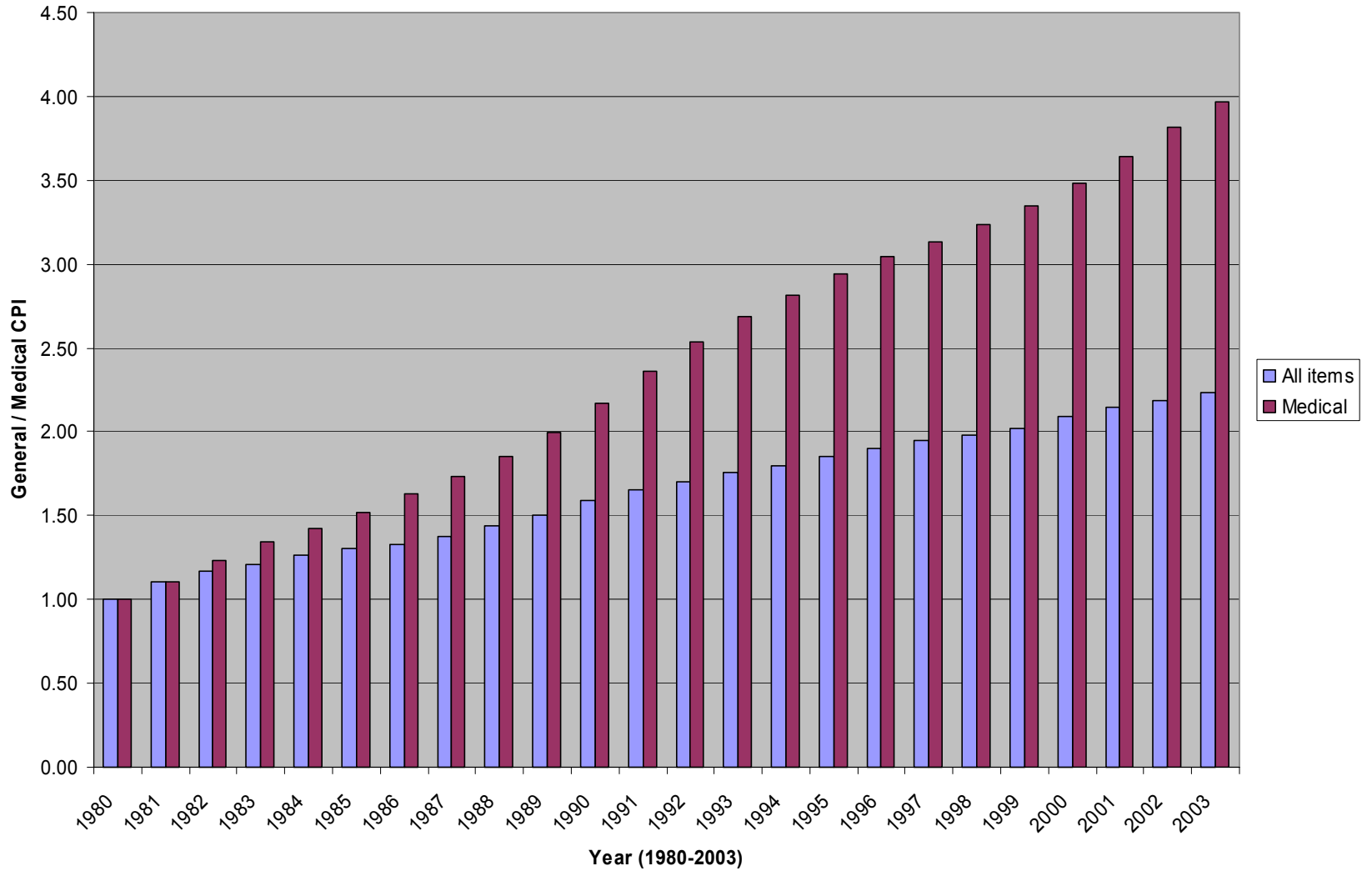
### Trends in Uninsurance



# Costs: Some Facts

- Unsurprisingly, health care inflation has grown faster than the general rate of inflation.
- From 1980 to 2003, general prices doubled, while medical prices quadrupled.

# Health Care Inflation



# Costs: More Facts

- Premiums for a family plan currently run upwards of \$10,000 per year (*Feldstein, WSJ, 2004*).
- Campaign issue
  - Kerry: premiums for family plans in PA, OH, and MI have risen by approximately \$2,700 in past 4 years, while total premiums are around \$9,500.
  - About a 40% rise over 4 years.

# Costs: More Facts

- Rising premiums may be masked by reductions in other forms of compensation.
- Dr. Jonathan Gruber of MIT found in a 1994 study substantial shifting of costs in the form of lower wages.
- Half of the 2% raise pool at UK was used to offset rises in health care premiums, resulting in just a 1% increase in wages.

# Market Failures and Government Involvement

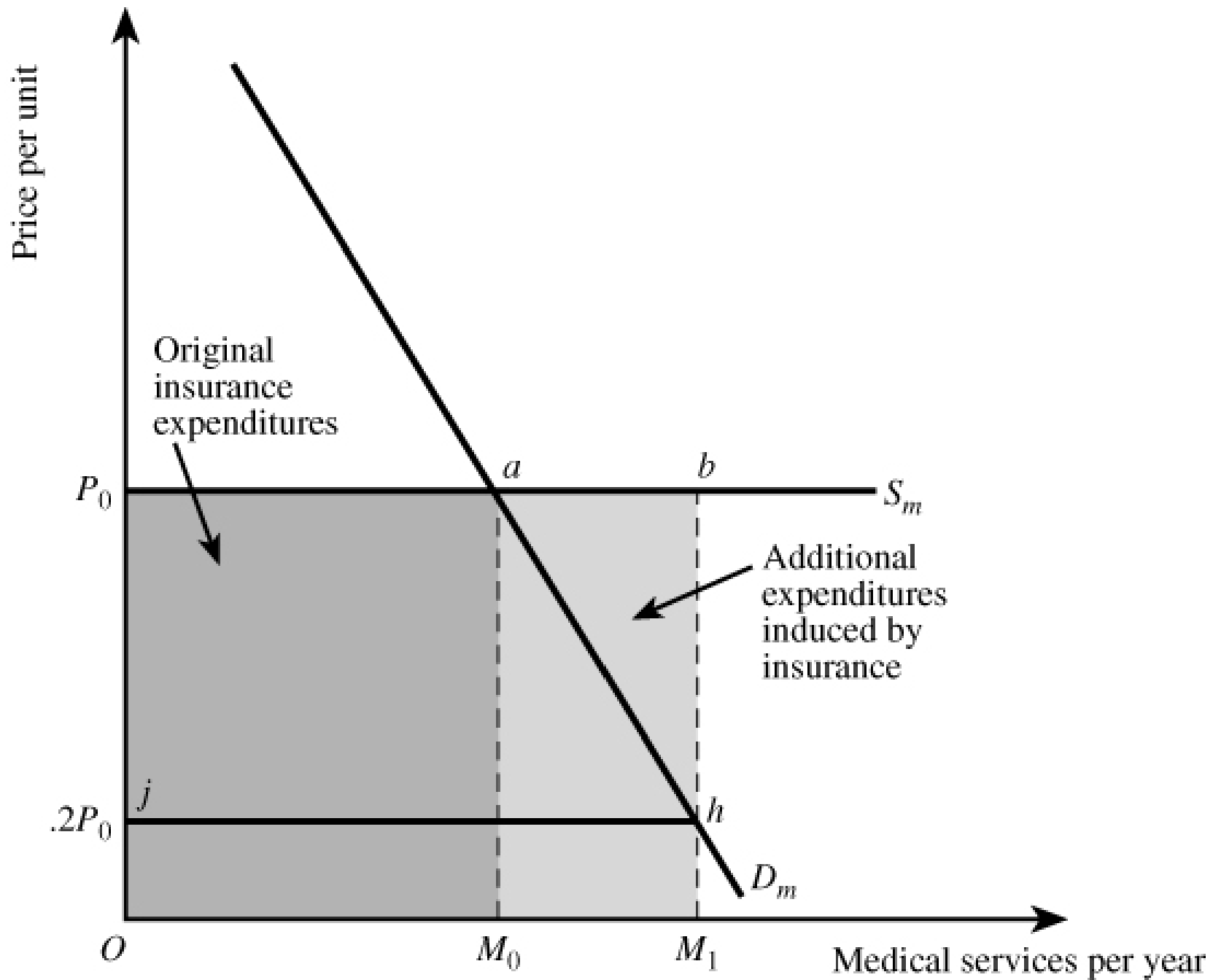
- The key question for economists is *why* should the government be involved in the health market.
- After all, there are other commodities (such as housing) that are important for survival with rising costs as well. Why health care and not housing?

# Market Failures and Government Involvement

- Economics suggests government involvement *may* improve economic efficiency when market “imperfections” are present.
- Two important imperfections in the health insurance market that are *not* present in a market like real estate are “moral hazard” and “adverse selection.”

# Moral Hazard

- Moral hazard means a person acts differently in the presence of insurance than they would in the absence of insurance.
- In a practical sense, this means that a consumer would see the physician more often when he or she has insurance to pay for the visit.



# Moral Hazard

- The supply and demand model illustrates that a person *may* consume more health care when there is greater cost sharing.
- How much? In an innovative experiment, Manning, *et al*, 1987 find that a 10% increase in out-of-pocket prices leads to a 2% reduction in health care utilization.
- Conclusion: Prices matter

# Moral Hazard

- Most current employer plans have low (or zero) deductibles and low coinsurance rates, leading to “over-utilization.”

# Moral Hazard

- The tax code in the U.S. has encouraged generous health plans through the exclusion of employer contributions for health insurance.
- Tax code changes the “effective price” of health insurance inducing employers to offer it, and to offer generous amounts.

# Moral Hazard

- Interesting, recent example involving 2 different Blue Cross Plans in California
  - \$500 per person (x2) deductible plan with \$8,460 annual premium
  - \$2,500 per person (x2) deductible plan with \$3,936 annual premium
- High deductible plan *should dominate* because save \$4,524 in premiums and *at most* pay \$4,000 extra in deductible

# Moral Hazard

- The tax code, however, may induce firms to choose the low-deductible plan.
- A family earning \$50,000 in California may face a federal tax rate of 25%, state tax of 5%, and a payroll tax of 15%, for a cumulative marginal tax rate of 45%.

# Moral Hazard

- If the \$4,524 premium saving from the high-deductible plan was turned into taxable salary ...
  - Net income would only rise by 55% of \$4,524
  - \$2,488 increase in income
- Thus, this rise in income may not be enough to pay the out-of-pocket expenses with high deductible plan discussed before.

# Adverse Selection

- Adverse selection means that a person who knows he is especially likely to collect benefits will have an especially high demand for insurance.
- In a practical sense, this means that sicker people are more likely to purchase insurance, or purchase more generous insurance.

# Adverse Selection

- The presence of adverse selection means that premiums collected by insurance companies may not be sufficient to pay out claims.
- Raising premiums only exacerbates the adverse selection problem, by leaving a sicker and sicker pool of people purchasing the policy.

# Adverse Selection

- Interesting study on Harvard employees when cost sharing was changed in the 1995
  - Harvard switched from paying a fixed percentage of each plan to a fixed dollar amount.
  - Thus, smaller percentage of more generous plans is covered by employer.
- Major finding: The healthy employees switched to the less generous plans, leading to an adverse selection “death spiral.”

# Policy Proposals: Some good, Some bad

- Malpractice Reform
- Health Savings Accounts
- Pay or Play Mandates

# Malpractice Reform

- “Defensive medicine” is a term that means a physician performs excessive tests or treatments because of fear of getting sued for malpractice.
- Patient goes along with extra tests because cost-sharing is minimal.
- Note that *most of costs* are not actually because of litigation.

# Malpractice Reform

- In rigorous study of heart attack patients, Kessler and McClellan (1996) find evidence of it.
- Malpractice reforms that directly reduce provider liability reduce medical expenditure by 5-9%.
- No changes in health or mortality.

# Malpractice Reform

- It is thought that excessive jury awards for non-economic damages lead to large malpractice insurance premiums for doctors.
- Wide variation in damage caps across states:
  - Kentucky: No cap on damages
  - Indiana: \$250,000 cap per provider
- May lead to physician migration but nothing conclusive found yet.

# Health Savings Accounts

- Medicare prescription drug law in 2003 also created *Health Savings Accounts (HSA)*
- Essentially a catastrophic plan with high deductible, much higher cost sharing, and some fungible cash for other purposes.

# Health Savings Accounts

- HSAs levels the “tax-subsidy” playing field between non-comprehensive plans and comprehensive plans.
- Qualified plan:
  - \$2,000 deductible
  - \$10,000 maximum out of pocket expenses
  - Up to \$5,150 pre-tax contributions for *any* health expenditure

# Health Savings Accounts

- Returning to the California Blue Cross example, creates greater incentives than before to purchase the high-deductible policy
- Could have effects on health care utilization because consumers now pay “full price” of care (less moral hazard).

# Health Savings Accounts

- Cautionary note, however!
- Many firms that would think of introducing HSAs would run into the *adverse selection problems* emphasized in previous research.
- For example, many young, healthy people may choose to opt-in the HSA, and opt-out when they anticipate medical expenses (for example, pregnancy).

# “Pay-or-Play” Mandates

- Another so-called “solution” to the uninsured is to mandate employer provided health coverage.
- Two days before California’s recall election, then-Governor Gray Davis signed California SB-2, which is a health insurance mandate.

# “Pay-or-Play” Mandates

- SB-2 mandated:
  - Family coverage must be provided at firms with 200 or more employees.
  - Individual coverage must be provided at firms with 50-199 employees.
  - Individual coverage must be provided at firms with 20-49 employees if California enacted tax credit.

# “Pay-or-Play” Mandates

- SB-2 is California law, and is scheduled to go into effect in January 2006.
- The “solution” to costs was to mandate that firms pay 80% (or more) of the premiums, with minimum benefit standards.

# “Pay-or-Play” Mandates

- In an October 2003 study, Yelowitz estimated that the cost of this mandate to employers would be \$10-\$11.4 *billion*.
- Much of the expense of the mandate does not even cover the uninsured.
- Host of implementation problems (e.g., the marginal cost of 200<sup>th</sup> employee could be \$1,000,000).

# “Pay-or-Play” Mandates

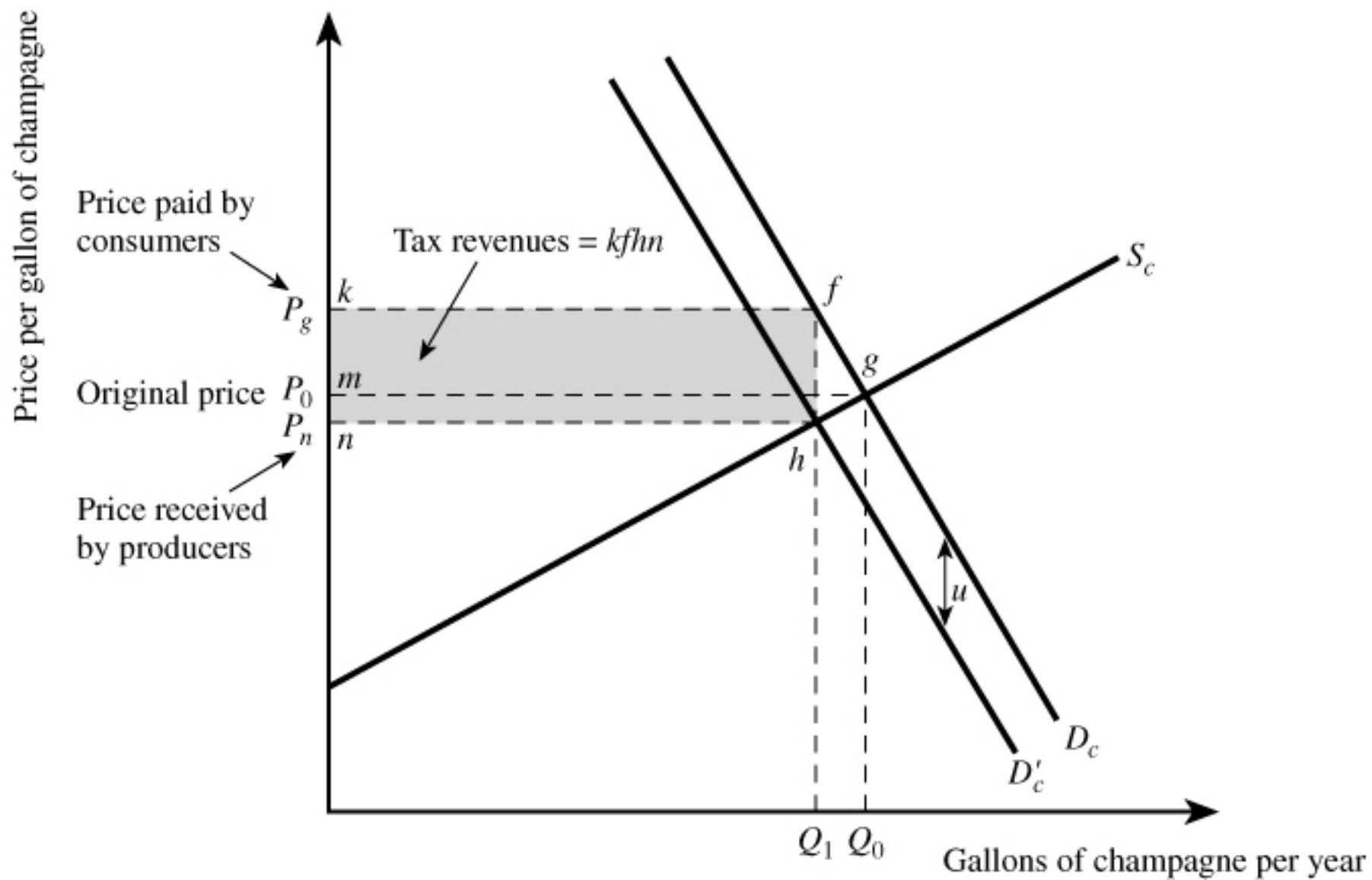
- In reality, cost to employers is likely to be lower because employers *adjust their behavior*.
  - Shift costs to workers through lower wages.
  - Layoff low-wage workers.
  - Relocate out of California.
- Many of these adjustments are even less desirable because of job loss.

# “Pay-or-Play” Mandates

- These adjustments are quite likely.
- Wage shifting found by Gruber (1994).
- Layoffs found by Neumark and Wascher (2000) in minimum wage context.

# “Pay-or-Play” Mandates

- Also, **basic confusion** on part of policy makers in terms of *tax incidence*.
  - In public finance, the legal incidence of a tax may not be the true, economic incidence, because the suppliers or demanders may be able to alter their behavior.
- Example: Employers “pass along” the 80% cost sharing in the form of lower wages.



# “Pay-or-Play” Mandates

- A repeal effort for California SB-2 is on the November ballot, but current polls suggest it will not be repealed.
- SB-2 may face ERISA challenges.

# Conclusions

- Policy proposals which reduce moral hazard problems could slow the growth in health care expenditure.
- There are many *bad* proposals out there, based on faulty economic premises

# Conclusions

- Thank you for listening!
- You can contact me at: [aaron@uky.edu](mailto:aaron@uky.edu)
- My web site, with these slides, is:  
<http://gatton.uky.edu/faculty/yelowitz>
- **If you are looking to hire talented undergraduates or graduates, please contact me!**